CODING AND COMPLIANCE

NEW APPOINTMENT AND REAPPOINTMENT MODULE FOR ANESTHESIA FACULTY
ANESTHESIA BILLING: MUST BE DOCUMENTED AS:

**Personally performed:** you perform the case without a resident or a CRNA and are in continuous attendance

**Teaching physician:** between 1-2 concurrent anesthetizing sites with residents

**Medically directed:** between 1 and 4 concurrent anesthetizing sites with CRNA’s, or 3 or more concurrent anesthetizing sites involving at least one resident

**Medically supervised:** anesthesia with more than 4 concurrent anesthetizing sites with CRNAs, or 4 or fewer anesthetizing sites with CRNAs whenever the 7 required steps for medical direction have not been met

This information is documented in the billing office based on a review of the anesthesia record, and is NOT documented by the anesthesia providers
1. Performs a pre-anesthesia examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
4. Ensures that any procedures in the anesthesia plan that the physician does not perform are performed by a qualified individual;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated post-anesthesia care.
WHAT IS NOT CONSIDERED AN ANESTHETIZING SITE DURING MEDICAL DIRECTION?

1. Performing one or more epidurals for analgesia on the labor and delivery suite

2. Performing one or more intubations outside of the OR and giving an anesthetic induction dose and/or a muscle relaxant

3. Performing one or more peripheral nerve blocks on patients in the pre-op holding area or in the PACU

4. Performing one or more epidurals to be used for post-operative pain management on patients in the pre-op holding area or in the PACU

Note that when a patient in the labor and delivery area with a pre-existing labor epidural goes to C-section, then this becomes an anesthetizing site, for the purposes of concurrency under medical direction
HOW ANESTHESIA SERVICES ARE PAID

Base unit value
  +
Time units (15 minutes = 1 time unit)
  +
Physical status modifier
  +
Any qualifying circumstances
  (extremes of age, emergencies, induced hypotension or hypothermia)
  +
PQRI incentives
  (normothermia, central line infection precautions, ect)
  +
Separately reportable procedures
  (pain blocks, arterial catheters, CVP and PA catheters, TEE)

Medicare/Medicaid does not pay for or recognize physical status modifiers or qualifying circumstances
PHYSICAL STATUS MODIFIERS

Physical status modifiers
All anesthesia services are reported using one of the following modifiers

Unit values

P1 - A normal healthy patient 0

P2 - A patient with mild systemic disease 0

P3 - A patient with severe systemic disease 1

P4 - A patient with severe systemic disease that is a constant threat to life 2

P5 - A moribund patient who is not expected to survive without the operation 3

P6 - A declared brain-dead patient whose organs are being removed for donor purposes 0
A basic value is listed for anesthetic management of most surgical procedures

- Base unit includes
  - pre and post anesthesia care
  - administration of fluids and/or blood products incident to anesthesia care
  - interpretation of non-invasive monitoring

- Base unit does **not** include
  - placement of arterial, central venous and pulmonary artery catheters
  - use of transesophageal echocardiography (TEE)
  - blocks for post-op pain management (peripheral nerve blocks, epidurals)
Anesthesia start and stop times

• Begins when the anesthesia provider begins to prepare the patient for anesthesia and stays in continuous attendance (e.g., start i.v., give medications, continuous vital signs monitoring)

• Ends after surgery is complete and the care of the patient can be safely transferred to a non-anesthesia qualified care provider.

• Anesthesia start should normally begin before the patient arrives in the operating room and anesthesia end should normally occur after the patient leaves the operating room.
QUALIFYING CIRCUMSTANCES

99100-Extreme age (Under 1 or 70 yrs or >) +1 Base Unit

99116-Hypothermia (20'C or below) +5 Base Units
   Should include documentation of “surgeon's request"

99135-Hypotension +5 Base Units
   Controlled or induced hypotension is billable only when done in a deliberate and formal manner and “per surgeon’s request"

99140-Emergency +2 Base Units
   “[A]n emergency is defined as existing when delay in treatment of the patient would lead to significant increase in the threat to life or body part.”
**GENERAL ANESTHESIA**

- *Per the 2014 Relative Value Guide book (page 45)*
- “If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required.”
- A surgical case done under MAC, regional or general is paid the same, irrespective of the type of anesthesia
MONITORED ANESTHESIA CARE (MAC)

• *Per the ASA Relative Value Guide – Position on MAC (page 45)*

• “Monitored anesthesia care includes all aspects of anesthesia care. Monitored anesthesia care may include varying levels of sedation, analgesia, and anxiolysis. The provider of MAC must be prepared and qualified to convert to general anesthesia when necessary.”